Claim For Reimbursement Summer Food Service Program Form SFSP (10/04)
Affix mailing label in space provided below. If label is not available fill in all information in its entirety.

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California Department of Education Child Nutrition Fiscal Services 1430 N Street, Suite 2213 Sacramento, Ca 95814

		$\perp \perp \perp \perp$									
Agreement Number	Vendor Number										
Name			2. Place "X" in the box if this is an		2 Month o	Month covered by this report			FOR STATE USE ONLY		
	S. MOHIT C	overed by thi			s report _	4. Adjustment		5. Reason Code			
Address		adjusted claim		MONTH	YEAR	₹					
City	State Zip										
_	<u> </u>		7 Number of appr	roved	7a. Of the ap	nroved sites	8 Total nu	mber of days	Ι ο Δ	Daile	
Period covered by this claim madays of the month preceding the operating days of the month follow	claim month or no more than					this claim period food service was provided Participation of eligible					
From:	To:										
Month Day Year	Month Day			_							
FOOD SERVICE TO	,							URING CLA hether or not pay			
(Report only meals meeting	g the requirements in First Meals		ment.) nd Meals Total Meals			(morado am ook			,o.n. nao		
	1 list Wicais	00001	ia ivicais	Total	ivicais	15. Food (Costs			.00	
10. Breakfast Served						16. Food L	_abor (see	back)		.00	
11. Lunch Served						17. Other				.00	
12. Suppers Served						18. SUB	TOTAL	•		.00	
13. Snacks Served						19. Admin	istrative C	osts and Lab	oor	.00	
						20 TOTA	I PROG	RAM COS	rs	.00	
13.a CCNSP Snacks Served	Of the First Snacks reported on Line 13		Of the Second Snacks reported on			20. TOTAL PROGRAM COSTS			,		
	how many were CCNSP?	Line 13, how many were CCNSP?				FOR STATE USE O				LY	
14. FUNDS ACCRUED DI	URING THE MONTH	(See claim in	structions for details)								
A. Operational Program Income (Adu	It Payment)	C. Administra	ative Income (Donatio	ons & Gran	ts)						
B. Operational Income (Donations & Grants) D. Unspecifie			d Income								
I certify that to the best o	f my knowledge and	d belief thi	s claim is true	and cor	rect in all re	spects, that	records a	are available	to sup	port this claim,	
that it is in accordance w	ith the terms of exis	sting agree	ement(s), and t	hat I ha	ve not receiv	ved paymen	t for this o	claim. I reco	gnize th	nat I will be fully	
responsible for any exces given in connection with											
Federal criminal statutes	. I further certify tha	t all claims	s for reimburse	ement s	hall be subn	nitted to the	California	a Departmer	nt of Ed	ucation no later	
than the deadline of 50 declaims not being paid.	ays after the claim r	month (iter	n 3). I understa	and that	failure to su	ubmit claims	within th	e said dead	line ma	y result in such	
Print name of claim preparer	hone number of clain	n preparer			Date						
Signature of authorized official	nt name of authorized official			Title of authorized official							
DEPARTMENT OF E		ONLY:									
PROJECT#	<u>PCA</u>					PROJEC	<u> </u>	<u>CA</u>			
Operations 060	13004-0 \$				Administr	ration 06	13	006-0 \$			
Recoup OP 060	13004-0 \$				Recoup A	ADM 06	61 13	006-0 \$			
C/A Pay/Recoup 060 13004-1 \$					C/A Pay/R	Recoup 06	61 130	006-1 \$			
Operations Net Payment \$					Adminis	stration N	et Payn	nent \$			
							¢				
APPROVAL			DATE			_	\$PAYMEN	IT			